



TEXAS
Department of Family
and Protective Services

Mental Health Resource Guide

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Resource Guides

The purpose of Resource Guides is to provide information that helps you do your job better. This information includes reference material, procedures, and guidelines that assist you to complete the tasks required by policy.

It's important to remember that the information in Resource Guides *does not substitute for policy*. We may sometimes include policy statements, but only to illustrate the policy to which the information is related. We will highlight any policy that actually appears in the Resource Guide and will almost always include a link to the actual policy. For example:

Per [4222.2 Re-Allowing Placement](#):

If the caseworker learns of a detailed justification for changing the status of and considering placements in a foster family that is on Disallowed Placement status, the caseworker must elevate this consideration through the regional chain of command to the regional director.

CPS Handbook policy always takes precedence over what is in the Resource Guide. We try to keep policy and Resource Guides synchronized, but sometimes there is a delay. **If you have questions, always follow the policy in the Policy Handbook.**

Resource Guides provide important information on a range of topics, for the purpose of assisting and guiding staff to:

- make essential decisions
- develop strategies to address various issues
- perform essential procedures
- understand important processes
- identify and apply best practices

The information in the Resource Guides is not policy (except where noted), and the actions and approaches described here are not mandates. You should adapt the way you perform critical tasks to the individual needs and circumstances of the children and families with whom you work.

State office and field staff are working together to identify Resource Guide topics, define the content, and develop the appropriate guides. CPS will regularly post Resource Guides as they are developed and update them as needed. Check the Resource Guides page, in the CPS Handbook, to see new or revised Guides.

We hope these Guides provide useful information to guide and assist CPS staff in effectively performing their job tasks. These Guides, combined with clear and concise policy in the Handbook, should help staff provide a high level of service to children in Texas.

Introduction

Our work is to help create opportunities for child safety to occur within families and communities. To do this, we partner with caregivers to help them protect their children and youth in new ways while building upon safety that is already present. We also work to establish safety networks for children and youth by organizing other important adults to create a safe environment now and over time.

Our hope is this practice guide provides child welfare workers with a balanced understanding of how one's mental health can impact the safety needs of children and their family members. In doing so, this guide aims to equip workers with information and intervention strategies proven effective in Texas and other states.

This reference guide is organized in the same manner as the Texas Child Protective Services Practice Model, the set of actions we carry out to achieve our desired outcome:

- Engaging
- Assessing
- Teaming
- Planning
- Intervening, and
- Evaluating

The Big Picture

Mental illness in America is a serious issue.

- One in four adults in America experience mental illness in a given year, according to the National Alliance on Mental Illness (NAMI).¹
- One in seventeen people live with a serious mental illness like schizophrenia, major depression or bipolar disorder.
- Forty-two million people have been diagnosed with an anxiety disorder, panic disorder, PTSD, generalized anxiety disorder or other phobias.
- Over 9 million Americans have been diagnosed with both a substance use disorder and a mental health disorder.²

¹ National Alliance on Mental Illness, National Alliance on Mental Health. (n.d). *Mental Health by the Numbers*. Retrieved January 21, 2021, from <https://nami.org/mhstats>.

² Substance Abuse and Mental Health Services Administration (SAMHSA, 2019). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. Retrieved January, 21, 2021 from <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf>.

- Approximately 26% of adults residing in a homeless shelter have a mental health issue ³, according to NAMI.
- Between 20 and 21% of state and local jails have inmates with recent mental health issues.
- “Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults ages 18 to 44.” ²

Mental health issues often also exist in child protection cases, impacting a family’s ability to provide for their needs. Mental health issues add additional risk factors to a family, including an increased risk of chronic medical conditions, increase in suicide, increased risk to drop out of school, and a shortened life span. Adults with serious mental illness like schizophrenia tend to die 25 years earlier than other adults without mental illness.¹ The Adverse Childhood Experience Study has even found that having a parent with a mental health disorder adds a risk factor to a child’s life that, combined with additional risk factors, may increase the child's exposure to medical ailments and decrease the child's overall quality of life.⁵

Causes of Mental Illness

The causes of mental illness continue to be studied but current research points to three primary factors:

- Biological
- Environmental
- Psychological causes

A *biological* cause may be the result of a genetic predisposition, a neurological issue, prenatal drug exposure, substance abuse, poor nutrition, brain injuries or some infections.

An *environmental* cause may be the result of lead exposure for a child, or other stressors such as a parent's substance abuse, losing a job, etc.

A *psychological* cause may be the result of abuse and neglect, trauma or even the early loss of a parent.⁴

The section below provides additional details and bases for questions that you must answer to identify these needs, which move you forward in your decision-making process. Engaging the family helps you identify these needs; further engagement, along with supervision, helps you to address those needs as part of your day-to-day work with children and families.

³ Tracy, N. (2019, October 23). Mental Health Statistics: You Are Definitely Not Alone, HealthyPlace. Retrieved on 2021, January 21 from <https://www.healthyplace.com/other-info/mental-illness-overview/mental-health-statistics-you-are-definitely-not-alone>

⁴ Web MD, <http://www.webmd.com/mental-health/mental-health-causes-mental-illness>.

⁵ Adverse Childhood Experiences (ACE) Study, Child Maltreatment, Violence Prevention/Injury Center, CDC. <http://www.cdc.gov/violenceprevention/acestudy/>.

Engaging

Engaging with children, mothers and fathers requires you to have some overarching consistencies in your practice and requires tailoring aspects of your approach to the individual and his or her role in the family. In approaching each person, you will be most effective if you use a respectful, professional and patient approach and provide an honest description of why you are there and how everyone's input will be needed to ensure child safety. You cannot implement the new approaches to working with families if you do not engage them. How the case and relationships begin can influence each of the subsequent actions.

Engaging Children: What You Should Know

When engaging children, it's important to remember that children impacted by mental illness develop many fears.

Fears for themselves:

- They will develop the illness
- They will be blamed for either causing the illness or for failing to protect their parent
- They face contradictory expectations: to be 'grown up' and 'a caretaker' at home but a child at school, or contradictions between the expectations of different parents or even within the same parent between his or her 'ill' and 'healthy' self
- They will be bullied, singled out and/or stigmatized openly by other children and more subtly by adults, because of their parent's illness

What We Need to Know About Children

How are children exposed to a parent's mental illness?

- Seeing it
- Hearing it
- Trying to step in and support parents
- Seeing the aftermath
- Being denied what is owed to them (financial support, home)
- Being maltreated directly

What do children learn as a consequence of exposure?

- Poor coping skills
- Mimic self-harming behaviors
- Dangerous environments
- Role reversal

What are the factors that help explain how each child responds?

- The relationship she or he has with the parent with mental illness

- The extent of his or her own maltreatment at the hands of a parent
- The child's age
- The child's developmental stage
- The child's role in the family
- The child's personal characteristics (i.e. sense of self, mastery of tasks, security)
- How the caseworker interacts with each child and the extent to which each child feels safe with the caseworker

How might exposure to mental illness be traumatic for children at all stages of development?

- These children may have developmental delays in all areas
- These children may do poorly in school
- These children may have difficulty with social relationships/skills
- These children do not often maintain friendships
- These children may develop psychiatric illness at an early age

When engaging with children, it is important to remember to do the following:

- Remember to assure children that what is happening is not their fault.
- Help children to discuss their feelings; remember, children have very strong emotions and they may not understand how to express them. They may be anxious or have mood swings; however, this may not mean that they are having a mental health crisis. Children need help to talk about their feelings. Remember that stress and trauma greatly affect young children's normal development.
- Help children understand their parent's mental health condition to the best of their ability to comprehend. Use appropriate language and explanations. There are many books that discuss mental health.
- Help children identify others who they feel comfortable with, that they can go to for support. Make sure that children feel safe throughout the situation. This is critical as in order to maintain routines and a sense of normalcy children need to feel safe and secure.

Engaging Parents with Mental Illness

What We Need to Know about Parents Who Have Mental Illness

The avenues you take to achieve these goals will look different from case to case, based on family support networks, strengths and needs of the family, and possible referrals for treatment and intervention services. While following policy and using the Resource Guide, you should adapt the way you perform critical tasks to the individual needs and circumstances of the children and families with whom you work.

Assessing

Assessing families is part of a continuous process that involves gathering balanced and unbiased information to make well-informed decisions. Assessing is done throughout a case, not simply at the beginning or end. One way to assess families is by asking questions to obtain information. This Practice Guide promotes the use of thoughtful questions when faced with mental health worries. It is important to shift the responsibility of finding reasonable outcomes onto family members rather than us always telling them what to do, and questions are an effective way to do that. Below are a few examples of questions for both children and adults.

Questions for Children

1. When do you feel most safe with your mom or dad? What is happening then?
2. Tell me something good about yourself that I would never guess.
3. How do you want your parents to behave in the future?
4. What do you think needs to happen so that you can always feel safe?
5. Tell me a time when you told a trusted adult about what happened?
6. When has there been a time that mom/dad showed you she or he is ready to change?
7. If your dad or mom were here what would he or she say he or she wants for you in the future?
8. What do you think needs to happen next? Imagine yourself feeling one point better, what would I see? What are the smallest steps that you would like your mom/dad to show you?
9. What would you say is the coolest thing you accomplished last year? How did you do that?
10. Tell me about one or two good things that happen in your family.
11. What does the child need to feel safe in the situation? Questions to consider are:
 - Who does the child feel safe with?
 - What rules need to be in place to ensure nothing like this happens again?
 - Tool: Use your leverage to establish a safety network of informed people who the child feels safe with who will play a role in the safety now and in the future of the child/ren.
 - Examples of words to use for leverage may include:
 - *If we can't come up with a plan to ensure your children are safe, I may need to consult with the County Attorney's office regarding filing a court affidavit.*
 - *If we can't ensure that your children are safe, I may need to talk to my supervisor about what else is needed that may even include a Safety Plan, PCSP or formal placement of your children by the court.*

Questions for Adult Caregivers

1. What would your children say they worry about? (If younger, nonverbal children) If your children were old enough to talk about their worries, what would they say?

2. When you think about what kind of parent you want to be for your children, on a scale of 0 to 10 where 10 is you are just on track to where you want to be and 0 is you are off track, where would you scale it?
3. How have you been able to hold a job, get your kids to school or keep your cabinets stocked, your bills paid, etc.?
4. When your kids are 25 years old, what kind of parent do you want them to say you were when they were growing up?
5. When you think about what are the most important values you want your children to have, what are they? Who do they have in your life that values the same things you do?
6. Complete a behavior continuum chart with:
 - When you are a 10, following your treatment plan, what do your children, your partner, your neighbors, parents, etc., see you do with your family, etc.
 - When you are a 5, what do they see you do?
 - When you are not following your treatment plan, what do they see you do?
 - What do you need to hear or need to see from your safety network when you are at a 10, 5 or 0?
7. Has there ever been a time that someone shared with you that they were worried about your mental illness? What did they say? What were they worried about?
8. What are the parents' best hopes for their child?
 - If you were to ask the mom and dad what they want for their child, what would they say?
 - On a scale of 0 to 10 with 10 being they have their life on track right now as a parent to meet that goal for their child and 0 is they are really off track, where would they scale it?
 - What brings the parents up to that number?
 - What is one more thing they could do to try and increase that number by one point?

What to Look for When Working with Families Dealing with Mental Illness:

Find out if there are any other professionals working with the family.

If there are other professionals, try to work together as a team and coordinate efforts to assist the parent or child.

Obtain a history of the parents and/or child's hospitalizations and medications.

Find out if a mental health safety plan has been developed.

Find out if there a history of suicidal/homicidal thoughts or attempts.

Find out is there a support system in place that can help them or take care of the children if there is a crisis.

Find out if they have basic necessities. Remember that most parents who have mental illness are on disability or have little to no income.

- This increases the stress, as they may not be able to provide for the children.
- Also, there may be role confusion, with children assuming many of the adult roles. Remember to check in with the children and ensure that the service plan includes the children.

Warning Signs to Look for During Assessments

Warning signs, or "red flags", provide valuable insight, not only to you working with the family, but also to other family members acting as supports to the family. While warning signs themselves do not prove that mental illness is occurring, they do provide clues that the family may be struggling and in need of additional support. It is important to observe these signs and provide the help and support that is needed. Some common warning signs include:

- Confused thinking
- Prolonged depression (sadness or irritability)
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Strange thoughts (delusions)
- Problems with relationships
- Becoming distant from loved ones
- Unexplained financial problems
- Growing inability to cope with daily problems and activities
- Suicidal thoughts
- Numerous unexplained physical ailments
- Substance use

Of course, this is not a comprehensive list, but it does indicate the more common warning signs you might see when working with a family that is having trouble.

Importance of Trauma-Informed

It is important to remember that all behavior has meaning. Mental health behaviors may lead to chronic trauma. When a child's safety is compromised because of his or her parent's mental health, it strains the child's relationship with her or his parents. On top of this, a child may be traumatized by what she or he has seen and/or heard. It is important to let the child explain to you how he or she feels, instead of assuming the behavior is related to the parent's mental

illness. Why? In many cases it is possible the child was left feeling neglected, fearful, with their overall safety and sense of stability compromised.

- Trauma Informed Care is a structured response to trauma that helps an individual understand and respond to the event which harmed her or him. It assists with his or her healing both physically and emotionally. In addition, the parents we work with were often victims of trauma themselves when they were children. Until parents have been able to resolve their own trauma, they will not be able to help their children resolve their trauma. This may mean that both adults and their children need to seek professional counseling to resolve their trauma; but, the therapists should be trained in an evidenced based trauma therapy approach.
- According to the American Psychological Association, "Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives."⁶
- Trauma in a child can look like many things, including behavioral issues. Many times a child's out of control behavior is misinterpreted as a behavioral issue when it is actually a trauma response.

You need to be respectful of the client's knowledge about his or her illness and offer supportive guidance when working with families. When working with a family, you are not the expert on the family. The family is the expert of what works best for them.

Teaming

Teaming is defined as coming together as a team to achieve a common goal. One of the ways you do this in your cases is by helping families to identify and develop safety networks that will play important, long lasting roles in the lives of the children and families. Developing a strong safety network in families with mental illnesses creates new levels of safety for the children and establishes more clearly defined roles for the safety network members. Safety networks can help:

- Develop a shared **understanding** of what the concerns are. Those shared understandings will allow everyone to understand the role they will play in the family's success and provide everyone with the why, what, and how of what everyone is doing.
- Allow for **participation** so that everyone's voice can be heard. This gives the safety network the freedom to share the concerns they have for the family and acknowledge the strengths

⁶ Adapted from the American Psychological Association Help Center article, [Recovering emotionally from disaster.](#)"

that they have observed in the family. It also allows for the group to have a sense of ownership in the safety and wellbeing of those they care about and are there to support.

- Create a **shared commitment** to the desired outcomes.

Using Teaming in Our Work

You collaborate with the family to identify appropriate safety network members and bring those people together in an honest discussion about the current concerns and the short and long-term goals for the case and the family. The family and safety network then work together with a shared understanding of what needs to occur to ensure child safety. Safety network members identify who among them can assist with certain tasks and they all leave with a sense of ownership for the family's success. These safety network members can provide a sounding board to a parent who is struggling with mental illness, can model safe and appropriate parenting, can provide transportation assistance, or do other things that together will ease the stress of changing some unhealthy habits that have put the children in potentially dangerous situations.

There are numerous points to be mindful of when working with families with mental health issues in child protective services:

- Have a basic understanding of mental illness. It is helpful for you to assist with decreasing the stigma of a mental illness. If you normalize mental health issues and have empathy for families, then they will most likely follow through with the service plan.
- It is important to understand that stress can increase mental illness symptoms. Many times the families that you work with are under enormous amounts of stress and your intervention may aggravate the situation; so you need to be mindful of this when addressing issues and service planning.
- The families you serve may have been impacted by trauma, which affects families differently. It is important for you to be mindful of this and realize that all service planning needs to be individualized; for example, everyone doesn't need parenting classes and there are other services that may be more suited for the individual or family.
- Be respectful of the client's knowledge about her or his illness and offer supportive guidance when working with families, remembering that our families are the experts of what works best for them.
- If the parent's mental health continues to go unchecked, what is your worry for the future for the child?
- Do other people involved in your case worry about will happen to the children? What do they worry will happen?
- This is your danger statement that can be added to your map that includes worries, strengths and next steps.

Planning

Much like assessing, planning is part of a continual process that occurs throughout the case and changes as the case evolves. When speaking specifically about cases involving mental illness, you should think of developing plans to help the parents. These plans will need to be specific to the needs and resources of that particular family, as no two families have the same needs and supports.

These plans can include mental health assessments where there is reason to believe that a person may need some type of treatment intervention. A plan can also include less formal support systems such as identifying appropriate support friends or family members that can assist this parent as he or she works on the treatment plan.

The following is a list of resources that can assist with planning with children and their families:

See Investigation Policy [2390 Families Who Are Unable to Obtain Mental Health Services for Children with Severe Emotional Disturbance](#)

http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2200.asp#CPS_2392

[Investigation and Referral to DSHS Residential Treatment Center Bed Resource Guide](#)

https://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/RTC_Resource_Guide.pdf

DSHS Mental Health Services for Children and Adolescents- Family Guide Children's Mental Health Services <https://www.dshs.texas.gov/mhsa/mh-child-adolescent-services/>

NAMI Texas

<http://namitexas.org>

Mental Health America of Texas

<http://www.mhatexas.org/>

Intervening

As with all cases, intervening in mental health cases means setting a bottom line for child safety. The interventions you use with the families you engage with will all be unique to the families.

This is because these families all have different strengths and resources available to them. An intervention applicable in a family living isolated from appropriate supports may be overly intrusive for a family with a strong and motivated support network.

One of the best and most effective tools available to assist you with your interventions is the safety plan.

Before we explain what makes for a good safety plan we must define what does not make for a good plan. A good safety plan does not require completing a service. While completing a service, such as completing a psychological assessment, is important and very likely to have a positive impact on the parent, it does not by itself create a safe environment for the child. A good safety plan should include these components:

- It should be action-oriented
- It should be case specific
- It should be rigorous

Let us examine these components further.

Developing a Plan that is Action Oriented

- A good safety plan should incorporate a specific, action-oriented task that needs to occur and will directly increase child safety. For example, you might have to determine whether or not services are necessary to resolve the mental health concern. Additionally, you will need to look at the following:
 - For example, is a mental health hospitalization needed to stabilize the parent?
 - If services are necessary, what has the parent found helpful in the past?
 - How would services build your confidence that the children would be safer?
- The second quality of a good safety plan is case-specificity. Based on the above example, an action-oriented task would be meaningless if the family did not have a support system that included safe and supportive individuals willing to take on these roles.
- Finally, the third requirement is that it be rigorous. A good plan is rigorous and thorough and details exactly what needs to occur and who is responsible for that action. A rigorous plan also explains why a task is being required and the consequences of failing to follow the plan. You might ask, if this problem was resolved, what would everyone be seeing that would give them confidence nothing like this would occur again?
- This is your safety goal for the case; you may have more than one.
- Safety goals are the presence of the good behavior in the absence of the behavior that got child protection involved.
- An example of a safety goal for depression could be:

CPS will be confident to close their case when everyone on the safety network can see that mom is taking her medication and seeing her doctor, as the doctor is recommending making sure that she

feels happy and can get up in the morning, feed her children, get her children off to school and do all the other things that mommies do to parent their children.

When You Think That a Parent is Having a Crisis, the following are Some Steps to Follow

Ask how they are feeling.

One thing to remember is that when a person is having a mental health crisis, he or she might be feeling overwhelmed by many things, including thoughts, sensations, internal and external sounds or voices.

They often feel out of control, misunderstood and lack trust in others.

Remember to remain calm.

- If you are calm, then this can help the person to remain calm.
- Connect with the person and allow for personal space.

If the person is threatening to hurt themselves or others, call for assistance.

You can assist in intervening by referring the family to appropriate service providers and resources that address mental illness.

Effective Forms of Interventions that Can Assist Families Dealing with Mental Illness

Psychotherapy

Psychotherapy can be an effective form of intervention. Several types of therapy may be helpful.

- **Cognitive behavioral therapy.** This is a common form of individual therapy. The focus of cognitive behavioral therapy is identifying unhealthy, negative beliefs and behaviors and replacing them with healthy, positive ones. In addition, therapy can help parents learn effective strategies to manage stress and to cope with upsetting situations.
- **Family therapy.** Family therapy involves the parent and his or her family members. Family therapy can help identify and reduce stressors within the family. It can help the family improve its communication style and problem-solving skills and resolve conflicts.
- **Group therapy.** Group therapy provides a forum to communicate with and learn from others in a similar situation. It may also help build better relationship skills.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy is geared mainly for people who have episodes of severe depression with suicidal tendencies or for people who haven't seen improvements in their symptoms despite other treatment. Electroconvulsive therapy is a procedure in which electrical currents are passed through a person's brain to trigger a seizure. Researchers don't fully understand just

how ECT works. But it's thought that the seizure causes changes in brain chemistry that may lead to improvements in a person's mood.

Medication

Medication is a form of intervention and it can be very useful for severe cases of mental illness. There are three main types of medication therapy:

- Antipsychotics
- Mood stabilizing medications
- Antidepressants

Hospitalization

In some cases, people with mental illness may benefit from inpatient hospitalization. Hospitalization for psychiatric treatment can help stabilize moods. Other options include partial hospitalization or day treatment programs.

Prevention

There's no sure way to prevent a mental health crisis. However, treatment at the earliest sign of a mental health disorder can help prevent it from worsening. Long-term preventive treatment also can help prevent minor episodes from becoming full-blown episodes of mania or depression.

Reminders for parents with mental illness:

- **Take their medications as directed.** Even if they are feeling well, they should resist any temptation to skip their medications. Remind them that if they stop, signs and symptoms are likely to come back.
- **Pay attention to warning signs.** Call their doctor if they feel an episode coming. Involve family members or friends in watching for warning signs. Addressing symptoms early on can prevent episodes from escalating.
- **Avoid drugs and alcohol.** Illicit drugs and alcohol may contribute to triggering a mental illness episode.

Evaluating

Evaluation is an ongoing process that helps you make informed decisions about the current safety of the families. You evaluate families continuously through contact with the parents, children and any other caregivers, and through input from collaterals from the safety networks. Additionally, you seek guidance from professional collaterals that have worked directly with

these families and have built partnerships intended to improve some area of the parents' life. It is important that you make these evaluations frequently enough that if any worries are identified, you can develop a timely plan.

One type of tool you have to evaluate children and/or parents dealing with mental illness is mental health assessments.

What You Need to Know about Mental Health Assessments

There are many types of mental health assessments that will help determine the treatment course for the children and families that we serve. Mental health assessments are completed for the following reasons:

- Find out about and check on mental health problems, such as anxiety, depression, schizophrenia, Alzheimer's disease, and anorexia nervosa.
- Help tell the difference between mental and physical health problems.

If a client that you are working with is experiencing a mental health crisis, then taking a mental health screening is one of the quickest and easiest ways to determine whether she or he is experiencing symptoms of a mental health condition. The assessment can be completed at a local hospital emergency room, primary care physician or an acute psychiatric hospital.

Psychological Evaluation is a formal way to measure traits, feelings, beliefs and abilities that can lead to people's problems. Some tests assess the presence of certain conditions, such as depression, anxiety, anger control or susceptibility to stress.

Psychiatric assessments, or psychological screenings, are a process of gathering information about a person within a psychiatric service, with the purpose of making a diagnosis. The assessment is usually the first stage of a treatment process, but psychiatric assessments may also be used for various legal purposes.

Glossary

Common Mental Health Conditions that Affect the Children/Adults we serve:

Schizophrenia

Schizophrenia is a group of serious brain disorders in which reality is interpreted abnormally. Schizophrenia results in hallucinations, delusions, and disordered thinking and behavior. People with schizophrenia withdraw from the people and activities in the world around them, retreating into an inner world marked by psychosis.

Contrary to popular belief, schizophrenia isn't the same as a split personality or multiple personality. While the word "schizophrenia" does mean "split-mind," it refers to a disruption of the usual balance of emotions and thinking.

Schizophrenia is a chronic condition, requiring lifelong treatment. But thanks to new medications, schizophrenia symptoms can often be successfully managed, allowing people with the condition to lead productive, enjoyable lives.

Symptoms

There are several types of schizophrenia, so signs and symptoms vary. In general, schizophrenia symptoms include:

- Beliefs not based on reality (delusions), such as the belief that there's a conspiracy against you
- Seeing or hearing things that don't exist (hallucinations), especially voices
- Incoherent speech
- Neglect of personal hygiene
- Lack of emotions
- Emotions inappropriate to the situation
- Angry outbursts
- Catatonic behavior
- A persistent feeling of being watched
- Trouble functioning at school and work
- Social isolation
- Clumsy, uncoordinated movements

Schizophrenia ranges from mild to severe. Some people may be able to function well in daily life, while others need specialized, intensive care. In some cases, schizophrenia symptoms seem to appear suddenly. Other times, schizophrenia symptoms seem to develop gradually over months, and they may not be noticeable at first.

Schizoaffective Disorder

Schizoaffective disorder is a condition in which a person experiences a combination of schizophrenia symptoms — such as hallucinations or delusions — and of mood disorder symptoms, such as mania or depression.

Not all experts agree that schizoaffective disorder should be treated as a distinct disorder. Some regard the condition simply as schizophrenia with some mood symptoms, while others view schizoaffective disorder as a separate disease with its own symptoms and treatments.

People with untreated schizoaffective disorder may lead lonely lives and have trouble holding down a job or attending school. Or, they may rely heavily on family or psychiatric group homes.

With treatment, people with schizoaffective disorder have a better prognosis than people with schizophrenia, but not as good as people with mood disorders alone.

Symptoms

The symptoms of schizoaffective disorder vary from person to person. Generally, people who have the condition experience psychotic symptoms — such as hallucinations, disorganized thinking and paranoid thoughts — as well as a mood disturbance, such as depressed or manic mood. They tend to be very antisocial and shunned by the people around them.

Psychotic features and mood disturbances may occur at the same time or may appear on and off interchangeably. The course of the schizoaffective disorder usually features cycles of severe symptoms followed by an improved outlook. To establish a diagnosis, a person must have demonstrated, at some point, delusions or hallucinations for at least two weeks without evidence of mood disorder symptoms.

Most commonly, the mood disorder accompanying the schizophrenic features is either bipolar disorder (bipolar-type schizoaffective) or depression (depressive-type schizoaffective).

Signs and symptoms of schizoaffective disorder may include:

- Strange or unusual thoughts or perceptions
- Paranoid thoughts and ideas
- Delusions — having false, fixed beliefs
- Hallucinations, such as hearing voices
- Unclear or confused thoughts (disorganized thinking)
- Bouts of depression
- Manic mood or a sudden increase in energy and behavioral displays that are out of character
- Irritability and poor temper control
- Thoughts of suicide or homicide
- Irrelevant or incoherent speech
- Catatonic behavior — lack of response, sometimes with an extreme agitation that's not influenced by the environment
- Deficits in attention and memory
- Lack of concern about hygiene and physical appearance
- Changes in energy and appetite
- Sleep disturbances, such as difficulty falling asleep or staying asleep

Bipolar Disorder

Bipolar Disorder — From high to low. From mania to depression. From recklessness to listlessness. These are the extremes associated with bipolar disorder, a mental illness characterized by mood instability that can be serious and disabling.

Bipolar disorder is also known as manic-depression or manic-depressive illness — manic behavior is one extreme of this disorder, and depression is the other.

The deep mood swings of bipolar disorder may last for weeks or months, causing great disturbances in the lives of those affected, and also in the lives of family and friends. Today, a growing volume of research suggests that bipolar disorder occurs across a spectrum of symptoms, and that many people aren't correctly diagnosed. Left untreated, bipolar disorder generally worsens, and the suicide rate is high among those with bipolar disorder. But with effective treatment, people can live an enjoyable and productive life despite bipolar disorder.

Symptoms

Bipolar disorder symptoms are characterized by an alternating pattern of emotional highs (mania) and lows (depression). The intensity of signs and symptoms can vary from mild to severe. There may even be periods when the person's life doesn't seem affected at all.

Manic phase of Bipolar Disorder

Signs and symptoms of the manic phase of Bipolar disorder may include:

- Euphoria
- Extreme optimism
- Inflated self-esteem
- Poor judgment
- Rapid speech
- Racing thoughts
- Aggressive behavior
- Agitation
- Increased physical activity
- Risky behavior
- Spending sprees
- Increased drive to perform or achieve goals
- Increased sexual drive
- Decreased need for sleep
- Tendency to be easily distracted
- Inability to concentrate
- Drug abuse

Depressive phase of Bipolar Disorder

Signs and symptoms of the depressive phase of bipolar disorder may include:

- Sadness
- Hopelessness

- Suicidal thoughts or behavior
- Anxiety
- Guilt
- Sleep problems
- Appetite problems
- Fatigue
- Loss of interest in daily activities
- Problems concentrating
- Irritability
- Chronic pain without a known cause

Depression

The persistent feeling of sadness or loss of interest that characterizes major depression can lead to a range of emotional and physical symptoms.

Symptoms

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities, including sex
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Low appetite and weight loss or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches digestive disorders and pain for which no other cause can be diagnosed

Additional Information

If you need additional information, additional resources, or other support please visit the Mental Health intranet page or contact the Mental Health Program Specialist.

512-438-3106

SOMH@dfps.texas.gov

Inpatient Mental Health Treatment

See [11600](#) Behavioral (Mental Health) Services and its subitems. Inpatient mental health facilities include the following:

- A state hospital, including Waco Center for Youth
- A private psychiatric hospital
- A psychiatric ward in a general hospital
- Any other mental health facility licensed or operated by DSHS that provides 24-hour inpatient mental health treatment (does not include a residential treatment center (RTC) licensed by DFPS)
- A psychiatric hospital operated by a state agency under contract with a local mental health authority or a local county (such as Harris County Psychiatric Center in Houston and the University of Texas Medical Branch at Galveston)

Health and Safety Code [§571.003\(9\)](#)

Patients are admitted to an inpatient mental health facility through voluntary admission by a person statutorily authorized to consent to that admission, or involuntarily through a court-ordered commitment.

Psychiatric Hospital Contact Protocol (For TMC and PMC Cases)

There may come a time when a child/youth in DFPS conservatorship is determined to present a risk of serious harm to himself or herself or others and is admitted to a psychiatric hospital. Hospitalization is an intervention designed to meet the child/youth's acute mental health needs and is not a long-term intervention. Admission to a psychiatric hospital is not a placement and should not be treated or referred to as such. In order to ensure a child/youth's needs are met during this time, there are very specific steps caseworkers must take immediately following notification of hospitalization. Those steps are outlined in this document, but it is important to note that all other policies and procedures must still be followed.

The steps outlined in the attached protocol apply to both children in DFPS conservatorship at the time of hospital admission and children who are admitted to a psychiatric hospital during the course of an investigation which results in DFPS taking conservatorship.

Notification Required Actions

Immediately, but no later than one business day after notification that a child/youth on your caseload has been admitted to a psychiatric hospital, the primary CVS Caseworker (INV

caseworker if CVS not assigned) must send an email to those who have a role in ensuring the youth's needs are met, as outlined below. Staff must also follow requirements for notification to the legal parties of the case as described in [6151.3 Notification Requirements and Schedule](#).

The Subject line must state: Psychiatric Hospital Admission – Child/Youth's Last Name, First Initial and PID. The body of the email must include the following information:

- Hospital name
- Patient Access Code if known
- Date of admission
- Reason for hospitalization
- Indicate if the child/youth will be returning to the placement after discharge from the hospital or if a new placement is needed
- Indicate if child/youth needs an updated psychological evaluation
- Name and Contact Information for Designated Medical Consenter/ or attach current Form 2085B Designation of Medical Consenter
- Name of school in which child/youth is currently enrolled
- Indicate if the child needs translation services (i.e. foreign language, deaf or hard of hearing)

The email **must** be sent to each of the following, unless indicated as not appropriate:

- [Psychiatric Hospital Referral Mailbox for the Region where the hospital is located](#) – For children/youth hospitalized out of state, the email must be sent to the Psychiatric Hospital Referral mailbox for the child's legal region and will be routed as appropriate.
- [Regional Placement Team Mailbox \(except in situations where the child is being served by a Single Source Continuum Contractor as a part of Community-Based Care\)](#) - Even if the child/youth is expected to return to the same caregiver after hospital discharge, notification to the Placement Team Mailbox is required as circumstances often change.
- [Single Source Continuum Contractor \(SSCC\)](#) - If the child/youth is being served by an SSCC as part of Community-Based Care, communication must be sent to the designated SSCC personnel per their regional joint operational manual.
- [Education Specialist](#) - If the child/youth remains admitted to a psychiatric facility for more than three days, the education specialist will coordinate educational services for the child/youth.
- [Well-Being Specialist](#) - For a child/youth with complex behavioral healthcare needs, the Well-Being Specialist is available to assist in multidisciplinary staffings, referral to internal and external resources, etc. See the [Medical Services Resource Guide](#) for detailed information. The Well-Being Specialist will be responsible for informing STAR Health of the youth's hospitalization.
- [Developmental Disability Specialist](#) - If the child/youth appears to have a developmental disability, the caseworker must also notify the Developmental Disability Specialist. The DDS will assist the caseworker with making referrals to community resources.

- Local Permanency Specialist - If the child/youth was previously assigned to a Local Permanency Specialist (LPS), the caseworker must notify the assigned worker and LPS supervisor, so the assignment can be placed on hold pending hospitalization.

Medical Consent Required Actions

Immediately, but no later than 24 hours after notification that a child/youth on your caseload has been admitted to a psychiatric hospital, the primary CVS Caseworker (INV caseworker if CVS not assigned) must provide the mental health facility with the name and contact information for the child's medical consenter as described in [11611.4 Consent for Health Care and Medications After Admission](#).

Unless the youth has been authorized to consent to his or her own medical care under *Texas Family Code §266.010*, the designated medical consenter must provide or deny consent for health care or the use of psychotropic medications once the youth is admitted.

When the Child/Youth is Not Returning to Placement

CHANGE MEDICAL CONSENTER: As described in [11611.5 Change of Medical Consenters While a Child or Youth Is Hospitalized](#) the caseworker reconsiders the designation of medical consenter if a child or youth is admitted to an inpatient psychiatric facility.

The caseworker follows the guidelines in the table below.

If:	Then:
the child or youth may return to the placement he or she was in before admission,	the caseworker determines whether there needs to be a change in medical consenter while the child or youth is hospitalized.
the child or youth will not return to the previous placement, and someone who is not a DFPS employee is the primary or backup medical consenter,	DFPS makes the caseworker the primary and backup medical consenter while the child or youth is hospitalized.
DFPS finds a new placement for the child or youth to go to after discharge from the inpatient facility,	the caseworker determines the most appropriate medical consenter, backup medical consenter, or both, based on the new placement.

PLACEMENT: If the child/youth is not expected to return to their placement, the Primary CVS Caseworker must send the assigned placement staff all items required for a placement search **within 24 hours of receiving notification.** Those items include:

- Updated application for placement
- Psychological or Psychiatric Evaluation
- Level of Care
- CANS, if completed
- Current therapy notes
- Letter from psychiatric hospital stating child/youth is no longer a danger to self or others
- See [Placement Process Resource Guide](#)

Note: If the child/youth is being served by the SSCC as part of Community-Based Care, the SSCC assigned staff person will obtain the above items as outlined in the catchment area's Operations Manual.

If there is a clinical recommendation for direct transfer to a State Hospital, the caseworker contacts the [CPS Mental Health Program](#) Specialist for next steps.

Notifying the Hospital of the Child's Sexual Victimization and Aggression History

When the caseworker is present at the time of admission, the caseworker must provide the Child Sexual History Report Attachment A to the *hospital care coordinator or similar hospital staff responsible for the child*, and must attempt to obtain a signature at the time of placement, provide a copy for the hospital, and upload the signed copy into One Case.

If the child is admitted by the caregiver, the caregiver is responsible for notifying the hospital of the child sexual victimization and aggression history at the time of admission. Upon being notified of the admission, the primary CVS caseworker must immediately but no later than three business days of being notified of child being admitted, ensure the *hospital care coordinator or similar hospital staff responsible for the child* is provided a copy of the Attachment A and must attempt to obtain the care coordinator or similar hospital staff's signature on the Attachment A, and upload into One Case.

4231.1 Notifying a Facility Regulated by Another State Agency of a Child's Sexual Victimization and Sexual Aggression History

Required Actions during Hospitalization

While the child/youth is in the psychiatric hospital, **the Psychiatric Hospital Worker, LPS or Other Designated Caseworker** must:

- **Immediately, but no later than 24 hours after notification that a child/youth has been admitted for psychiatric treatment, *confirm*** the mental health facility has been provided with the name and contact information for the child's medical consenter
- Make face to face contact with the youth at the facility within 1-3 business days of becoming aware of the admission, and weekly thereafter;
- Confirm that the hospital care coordinator or similar hospital staff treating the child have been provided with the Child's Sexual History Report Attachment A and are aware of the child's sexual victimization and sexual aggression history. Provide the form to the hospital care coordinator or similar hospital staff if not and attempt to collect a signature. If hospital staff refuse to sign, indicate who the form was provided to, date and indicate their refusal to sign. Upload into OneCase.
- Document weekly face to face contact in IMPACT in accordance with CPS policy.
- Request and send the youth's clinical record collected from the hospital to the primary caseworker and assigned placement staff or SSCC staff; ** the clinical record refers to any documentation of treatment services released by the hospital including the youth's Admission Summary, psychiatric/psychological evaluation, therapy notes, psychiatric progress or nursing notes, and medication status
- Communicate critical updates regarding the youth's treatment (i.e. discharge plan, basic care needs, safety issues) to primary worker within 24 hours of being made aware of the new information
- Coordinate and facilitate internal multidisciplinary staffings to assist with placement following discharge and securing services

While the child/youth is in the psychiatric hospital, **the Primary CVS Caseworker** must:

- Notify the child/youth's parent within 24 hours of notification (unless an exception listed under 6151.1 exists). As soon as possible, but no later than 10 days after admission, notify the GAL, AAL, parent's attorney and CASA; and
- Update the application for placement with the weekly progress/participation/therapy notes/medication compliance, etc.
 - If this child/youth is being served by the SSCC as part of Community Based Care, the assigned SSCC staff person will update the application for placement as described; and.
- Conduct **Required Monthly FTF** contact if child/youth is hospitalized in legal region. IF out of region, phone contact required.
- Contact the Regional Education Specialist to develop a plan to ensure the youth's educational needs are met for the duration of the youth's hospital stay.

EDUCATIONAL NEEDS:

Within three days of being made aware of the child's admission to the psychiatric hospital, **the Regional Education Specialist** will:

- Coordinate with the psychiatric hospital worker and primary caseworker to determine the education needs of the child or youth.
- Collect any needed education-related information from the primary caseworker to arrange educational services.

To arrange education services, **The Regional Education Specialist** will:

- Consult with child/youth's caseworker and caregiver for school withdrawal/enrollment process.
- Maintain weekly contact with the caseworker/psychiatric worker to address any changes in hospitalization of the child/youth and to assist with any school transitions upon discharge.

If the child/youth is not receiving special education services, **the Regional Education Specialist** will:

- Consult with the hospital to explore how best to meet the education needs of the child.
- Consult with the local school district on its policy for providing education services to children and youth who do not receive special education services or are not eligible for special education service when the student is confined at home or at a psychiatric or medical facility.

The Education Specialist should confer with their supervisor and the Education Program Specialist at State Office as soon as possible if efforts to obtain educational services for a child/youth are unsuccessful.

When Placement is Identified

As soon as a placement is identified, the Primary CVS Caseworker will send an email with the new placement's name, address, date of discharge from hospital/date of placement, transportation plan, and the name of the worker who will facilitate the placement to all of the following:

- Psychiatric Hospital Worker or LPS responsible for weekly contact
- Well-Being Specialist
- Primary Caseworker's supervisor
- Education Specialist

- Psychiatric Hospital to prepare child for discharge and so that hospital can share information about child with the identified placement

Note: If the child/youth is being served by the SSCC as part of Community Based Care, the SSCC assigned staff person will follow the placement process as outlined in the catchment area's Operations Manual.

Emergency Detention Order and Order for Protective Custody

See [11612](#) Emergency Detention Order and Order for Protective Custody.

Assistance From Law Enforcement

A caseworker or the residential child care provider may seek law enforcement assistance if he or she believes that a child needs a temporary involuntary mental health commitment and the child will not willingly be evaluated by mental health professionals.

Law enforcement has authority to assess the situation and, if the statutory requirements are met, use their authority under an emergency detention warrant to:

- take the child into immediate custody; and
- transport the child to a mental health professional for examination.

Basis for an Emergency Detention Warrant

Law enforcement may request an emergency detention warrant from a magistrate when law enforcement believes, and the magistrate determines, that a child:

- has a mental illness;
- is a danger to himself or herself;
- is a danger to others; or
- needs to be immediately restrained because of the imminent danger. Health and Safety Code

[Chapter 573](#)

Transporting the Child

Law enforcement usually transports the child to the county's designated mental health evaluation facility. Law enforcement may permit the caseworker or residential child care provider to transport the child, if the caseworker or residential child care provider believes he or she can safely transport the child.

When the Emergency Order Expires

The emergency detention order expires:

- 48 hours after it was signed by magistrate, or
- earlier, if either of the two examining doctors determines that hospitalization is not appropriate.

At the time the emergency detention order ends, the child must be released immediately, and the involuntary commitment process is over.

Order for Protective Custody in Interim Second Evaluation or Hearing

If the emergency detention order expires before a second doctor's opinion can be obtained or before the application for involuntary commitment can be filed and the case heard by the court, a new court order may be sought. The doctor or hospital asks the county attorney to seek an interim order called an Order for Protective Custody (OPC) to legally hold the child in the hospital until the second doctor evaluates the child.

If the doctor does not recommend hospitalization, the order ends, and the child is released. If the doctor agrees hospitalization is needed, then the OPC continues in effect until the hearing is held on the application for involuntary commitment. The county attorney can file an application for a temporary involuntary commitment for inpatient mental health treatment if both examining doctors agree that a commitment is needed.

Priority Setting for Hearings

Probate courts are required to give priority settings to hearings on involuntary commitments. Hearings are often set in a week or less.

Involuntary Commitment for Mental Health Services

A due process hearing occurs before a judge or jury. The judge signs an order if the judge or the jury finds that the child would benefit from a temporary involuntary commitment for inpatient mental health treatment.

The Health and Safety Code, [Chapter 254](#), governs admission to the hospital and any inpatient treatment services that are provided after a court order is issued. The order provides for an inpatient commitment for up to 90 days. A child may be released sooner if the doctors at the facility determine the child is able to be safely discharged.

If the doctor determines that the child cannot be safely discharged, the hospital seeks a new 90-day commitment or a voluntary agreement from the child and DFPS in order for the child to remain in the hospital.

Involuntary Commitment Order for Mental Health Services

When CPS staff or a residential childcare provider believes an order for involuntary inpatient mental health services (court commitment) is necessary for a child, then staff or the provider

contact the regional mental health authority (MHA), also known as regional MHMR, for assistance and assessment.

Medical Consenter's Role

The court order for mental health services directs the mental health facility to admit the child and provide general treatment (for example, milieu therapy or group therapy). However, the medical consenter must provide or deny consent for any health care and the administration of psychotropic medication, except in an emergency.

Application for Involuntary Commitment

Residential childcare providers may request DFPS assistance in pursuing court-ordered mental health services. The caseworker files an application for involuntary commitment for mental health services in the county of the child's placement at the time of the emergency. Jurisdiction for court-ordered mental health treatment is not part of a DFPS court case.

Before seeking court-ordered mental health services, the caseworker:

- obtains approval from the supervisor;
- notifies the regional attorney;
- notifies the child's attorney ad litem; and
- notifies the local mental health authority (MHA).

Criteria for Application

The regional MHA and its doctors make a determination of whether the criteria are met for an application for involuntary commitment. Two physicians' statements must accompany an application for a court ordered commitment, stating that inpatient hospitalization is needed. If the situation meets the criteria described in [11612](#) Emergency Detention Order and Order for Protective Custody, the caseworker or provider contacts law enforcement for assistance.

An application for involuntary commitment is filed with the local court with probate jurisdiction, to obtain an order for mental health services. In some cases, CPS staff or the provider may be asked to sign, while in other cases, MHA staff may sign the application.

The application must specify that the child:

- appears to be a danger to self or others and is in need of treatment in an inpatient mental health facility; and
- refuses voluntary treatment.

Health and Safety Code [Chapter 574](#)

Admission and Consent to Medical and Psychiatric Treatment Process

This chart identifies who must provide consent for admission, treatment and psychotropic medication administration (if applicable) when an individual under DFPS conservatorship is being admitted to an inpatient mental health facility. It is based on the type of admission and the party requesting admission.

Type of Admission	Party Requesting Admission	Party Consenting to Admission/Treatment/Psychotropic Medications
Voluntary	DFPS, the child's primary or back-up medical consenter or residential child care provider is seeking voluntary admission to inpatient psychiatric treatment for a child.	<ul style="list-style-type: none"> • DFPS and the child both consent to the voluntary admission; if one does not consent, then there is no admission. • The medical consenter or 16- or 17-year-old youth (if authorized to give own medical consent by DFPS court) consents or denies consent to health care and each specific psychotropic medication.
Voluntary	A 16 or 17-year-old youth seeks voluntary admission.	<ul style="list-style-type: none"> • The facility may admit the youth voluntarily without consent from DFPS. • The medical consenter or 16- or 17-year-old youth (if authorized to give own medical consent by DFPS court) consents or denies consent to any health care and each specific psychotropic medication.
Emergency Detention	DFPS, the primary medical consenter, back-up medical consenter, or the residential childcare provider seeks an emergency detention order from law enforcement and obtains it.	<ul style="list-style-type: none"> • A facility admits the child for a mental health evaluation by a doctor and may provide emergency treatment as necessary under the emergency detention order. • The medical consenter consents or denies consent to any health care and each specific psychotropic medication.

<p>Involuntary Commitment</p>	<p>DFPS, the primary medical consenter, back-up medical consenter, or residential childcare provider seeks an involuntary court commitment for mental health treatment for up to 90 days from a court and the court order is granted.</p>	<ul style="list-style-type: none"> • A facility admits the child based on the Order for Temporary Mental Health Services for up to 90 days and may provide emergency treatment as necessary. • The medical consenter provides or denies consent to any health care and each specific psychotropic medication. • A 16- or 17-year-old youth authorized by the court to consent to their own medical care may not consent if they are court committed.
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